Editorials and Association Notes

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Editor
F. G. ALLISON, B.A., M.D. (Man.), M.R.C.P. (Lond.)
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F. G. ALLISON, B.A., M.D. (Man.), M.R.C.P. (Lond.)
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J. GORDON WHITLEY
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The Poliomyelitis and Encephalitis Epidemics

During the past seventy-five years epidemics of the acute exanthemata have become less frequent and lost much of their virulence. During the same period epidemics of virus infections of the central nervous system have made their appearance and have steadily spread. Manitoba has suffered more from these new epidemics than any other part of the world.

During the period from 1919 to 1925, encephalitis lethargica attacked many hundreds, caused many deaths, and left an equal number totally incapacitated with Parkinsonism. In 1928 there were about 500 cases of poliomyelitis with 7% deaths, and an unknown number of paralytic sequels (possibly 20%). An epidemic of similar proportion and results occurred in 1936. In the intervals between epidemics and also since 1936, sporadic cases of various types of encephalomyelitis have not been infrequent. These have usually been diagnosed as lymphocytic choriomeningitis, or, in recent years some have been attributed to the equine virus.

In June of this year an epidemic of poliomyelitis made its appearance and is still not abating. Though this epidemic is larger than those of 1928 and 1936, fortunately, the mortality and paralysis appear to be definitely lower than in other years. (This may be partly due to more general recognition of abortive cases). One curious feature of the epidemic is the great frequency of palatal paralysis (usually the right side).

In the midst of this epidemic (July), cases of encephalitis appeared and have already caused more deaths than poliomyelitis. Over 200 cases have already been diagnosed and the mortality appears to be about 20%.

As a rule the clinical differentiation between these two diseases is not difficult. They are contrasted in many respects:

1. *Age Incidence:* Encephalitis begins in the age groups where poliomyelitis leaves off. Roughly 50% are over fifty and few are under twenty.

2. *Sex Incidence:* About 80% of the cases have been males.

3. The onset is much more violent and the febrile course more prolonged in encephalitis. On an average, acute indisposition lasts for two days in poliomyelitis and for seven days in encephalitis.

4. Encephalitis is characterized by prolonged severe frontal headache and cerebral symptoms (apathy, lethargy, delirium, disorientation and coma; paralysis of muscle groups does not occur). In contrast, the headache in poliomyelitis is mild and of short duration. Cerebral symptoms are rare (except in infancy), but muscle weakness is common, even in those who do not develop actual paralysis.

5. The cerebro-spinal cell count is almost invariably increased in both diseases. There are minor differences in the differential count.

The identity of the virus responsible for the encephalitis has not been established. Clinical findings are quite distinct from encephalitis lethargica but are similar to cases described in the St. Louis epidemic (1933) and those at present appearing in Minnesota and the Dakotas. It is possible, also, that the western equine virus is contributing some cases. There may even be mixed cases.

There is no specific treatment for encephalitis. Since pneumonia is a common complication, it is suggested that prophylactic doses of sulfapyridine be given (seven and a half grains, four times a day). Complete rest from the onset of symptoms is imperative and appears to influence the course of the disease. Lumbar puncture often relieves the symptoms; chloral and bromides per rectum are useful in delirium.

River's Opinion of Serum Treatment of Poliomyelitis

Thomas M. Rivers, Director of the Hospital of the Rockefeller Institute for Medical Research, and noted authority on Poliomyelitis, in a lecture given in April, 1941, published with other lectures on Infantile Paralysis by the National Foundation for Infantile Paralysis, Inc., 120 Broadway, New York City, says:—

"Naturally occurring poliomyelitis in human beings and the experimental disease in monkeys do not always protect against second attacks of the malady. It is difficult to protect monkeys by vaccination without inducing the disease, and, as yet, no safe, efficient vaccine has been devised for human use. The role played by neutralizing antibodies in resistance to and recovery from infection is not known. Poliomyelitis can occur in human patients possessing ample amounts of neutralizing antibodies for the virus. Monkeys as a rule and human beings not infrequently recover from the disease before the appearance of circulating neutralizing antibodies. Administration of large amounts of neutralizing antibodies to normal monkeys protects only a few of them against infection. There is no definite evidence that serotherapy administered to human beings, even in the preparalytic stage, is efficacious."

Indians

The Indian population of Manitoba is frequently referred to in tuberculosis articles but rarely mentioned otherwise in medical journals. In this issue of the *Review* Dr. Walkin presents an amusing and informative article on the character, mode of life, and diseases of the Interlake Indians.

On a recent trip to Norway House the writer was able to confirm many of Dr. Walkin's observations. The 800 Swampy Crees on this reservation are all said to have some white blood, but whatever the proportion of the mixture the dislike of present work for future benefits is well-nigh universal. Indians can be hired to build a dock or a wood pile, but never attempt to do so on their own property. Indians on relief, with the forest at their back doors, requested that fuel be provided, on the ground that this was done in Winnipeg.

The most amusing trait noted was the giving of bizarre Christian names. The surname is usually Scotch. Common Christian names vie with Biblical Christian names in popularity, e.g., Job, Zebuchadnezzar. Some names were taken from packing cases, like Sherwin-Williams, Harris Abbatoir and Canada Packers. The latter did not use his middle name much, and was usually just called "Canada."

Counter Propaganda Reaches *The Lancet*

Philip Manson-Bahr finishes a gloomy and detailed account of "The Prevalent Diseases of Italian East Africa" in *The Lancet*, May 10, 1941, p. 609, with the following blast against Sir Aldo Castellani, formerly of Harley Street and now Mussolini's number one worm catcher:—

"Public opinion regarding the nosology of Abyssinia may have been greatly influenced by the official medical reports on the Italian conquest of that unfortunate country; these presented a rosy picture, whereas, on the evidence of the Italian observers quoted in this paper, none of the territories under consideration can honestly be described as health resorts. Some reference is obviously necessary to the account which Castellani has given to the world in his papers and lectures on the hygienic measures and hospital organisation of the Italian expeditionary forces during the Ethiopian War of 1935-36. Even a cursory examination demonstrates that the figures are to a large extent fallacious. It is necessary to emphasise this point since this report has been widely cited as the outstanding example of modern military hygienic achievement (see Scott 1939). It is only necessary to refer to a few of the obvious anomalies. The number of white troops engaged was over 500,000, and during the 7 months of war deaths from disease (including those from accidents such as drowning) numbered 599, which gives a figure for the annual death rate of 2 per 1,000; this puts the death rate of the Italian Army at less than 2.9, the lowest annual figure ever recorded for the age groups 20-30 in the Registrar-General's Report for England and Wales under peace conditions and lower than the lowest to be recorded for the Italian Army in Italy. Nor need we regard seriously the remarks on the low incidence of malaria among the Italian troops during this campaign; this was ascribed to quinine prophylaxis in one of the most malarious countries in the world, in direct contradiction to the testimony of the Italian medical officers quoted in this paper. In a country teeming with tapeworms only two were noted in the Italian Forces. It can therefore be surmised that in this case political propaganda has overridden statistical accuracy."

New Uses for Sulfathiazole

In a discussion on Chemotherapy in Vancouver in June, reported in the August number of the *Bulletin* of the Vancouver Medical Association, p. 327, Dr. Osgood spoke as follows:—

"The drug of choice for local use is sulfathiazole, because this drug has proved the most effective compound. We feel that when we have a considerable local collection of pus the local use of the drug is important because large numbers of organisms are not sterilized by any of these drugs, so where there is a local collection of pus not due to the tubercle bacillus but due to almost

any other organism, we like to get a blood level of sulfathiazole between 5 and 8 mg. That blood concentration will take care of the small number of organisms that might be in the blood stream or in the adjacent tissue. As soon as that level is obtained by use of sodium sulfathiazole intravenously, the local collection of pus should be drained and the pus or necrotic tissue all washed away with saline solution saturated with sulfathiazole. That takes about 1 gr. per litre to make this solution. Then powdered sulfathiazole is applied locally in excess. Except in the general peritoneal cavity, or where there is a very large absorbing surface, the amount of sulfathiazole does not make much difference, for the reason that it is soluble only about to the amount of 1 gr. per litre.

"The method of applying the local sulfathiazole depends upon the type of the infection rather than the location of the infection; e.g., a compound comminuted fracture — rinse it with the saline saturated with the sulfathiazole, pack it with sulfathiazole and it can be sewn up like a clean wound. In a great majority of instances it will heal by first intention. In general peritonitis, as soon as the blood level is obtained — immediate operation, closure of the opening, rinsing out the peritoneal cavity with saline saturated with sulfathiazole poured in or sprinkled in with a salt cellar. After tooth extraction we have had a considerable series of osteomyelitis of the jaw. We now simply pack the powdered sulfathiazole into the infected socket afterward. Or with something like a brain abscess, the abscess is opened and with a catheter we rinse out the cavity with saline saturated with sulfathiazole, put in a very heavy suspension, anywhere from 2 to 10 grs. to 20 c.c. of the saline. You have to shake it in order to maintain it in suspension. In sinuses, rinse the sinus free from pus and put in the saline suspension. In all streptococcic throats we have been using powdered sulfathiazole with a powder blower, blown into the throat. It is completely non-irritating. In G.C. ophthalmitis you can give a saturated solution by a continuous drip. For those very rare cases of gonorrhœa which do not clear up with sulfathiazole by mouth, we use sulfathiazole intra-urethrally. We have had quite a number of cases in the male that have failed to respond to the drug by mouth — out of a very large series — and they have cleared up with intra-urethral administrations. In the female we use this in a contraceptive diaphragm over the cervix."

Dr. Perrin Long said that in children with long standing pychonephritis and poor urinary function tiny doses of sulfathiazole 5 times daily would control the urinary infection without giving too high a blood concentration. He approved of sulfanilamide for long periods of time in patients with acute nephritis. In measles prophylactic sulfanilamide 10 grains thrice daily for adults cuts down middle ear infection, sinusitis, bronchitis and pneumonia.

Dr. Struthers recommended sulfathiazole in scarlet fever to diminish cervical adenitis and mastoid infections.

Personal Notes and Social News

Conducted by Gerda Fremming, M.D.

Dr. Doreen Corke of New York City spent a short visit with her parents, Mr. and Mrs. G. B. Corke, at Little Britain, Man.

♡ ♡ ♡

Dr. and Mrs. Brian Bird of Brandon, Man., have recently returned from a holiday trip through the province of Quebec.

♡ ♡ ♡

Dr. and Mrs. B. Kanee of Weyburn, Sask., are receiving congratulations on the birth of a son, Benson Harold.

♡ ♡ ♡

Dr. and Mrs. Stanley Herbert and family have returned from the Lake of the Woods, where they spent the last five weeks.

♡ ♡ ♡

Dr. and Mrs. Oliver S. Waugh were recent guests at Minaki Lodge, Minaki, Ont.

♡ ♡ ♡

The engagement of Dr. James A. Porter to Miss Marie Rose Gratton has been announced. The wedding will take place in September at St. Edward's church, Winnipeg.

♡ ♡ ♡

Dr. and Mrs. William Malyska of Waskada, Man., are receiving congratulations on the birth of a daughter on August 12th, 1941.

♡ ♡ ♡

Dr. R. G. Green recently returned from a holiday trip in Eastern Canada.

♡ ♡ ♡

Drs. Lennox Bell, Gordon S. Fahrni and F. G. McGuinness of Winnipeg will attend the Annual Meeting of the British Columbia Medical Association.

♡ ♡ ♡

Dr. and Mrs. Digby Wheeler left by motor for Banff. From there they will proceed by train to Vancouver, then by boat to Alaska. On their return they will visit Lake Louise and Jasper, arriving in Winnipeg early in September.

♡ ♡ ♡

Dr. and Mrs. E. S. Moorhead were guests at the Chalet, Wasagaming, Man., where they spent a short holiday.

♡ ♡ ♡

Dr. George S. Baldry of Winnipeg has left for Toronto, where he will take a course in post graduate work at the University of Toronto.

♡ ♡ ♡

Dr. and Mrs. M. R. MacCharles and family are vacationing by motor through the Rocky Mountain District. Banff, Lake Louise, Kootenay Lakes and other points of interest are included in their itinerary.

Dr. and Mrs. T. W. Shaw, Marney and Eleanor, of Russell, Man., are holidaying in Ontario.

♡ ♡ ♡

Dr. and Mrs. H. H. Hutchinson of Neepawa, Man., have returned from a holiday trip to Vancouver and Victoria, B.C.

♡ ♡ ♡

Dr. and Mrs. Gerard Allison recently returned from a visit at Norway House, Man.

♡ ♡ ♡

Dr. and Mrs. Cyril Stevens chose Hawk Lake for a two weeks' vacation.

♡ ♡ ♡

Drs. Kay and Walter Leslie and son, David, have left for the Lake of the Woods to spend their vacation. While there they will be guests at the summer home of Dr. and Mrs. A. E. Deacon.

♡ ♡ ♡

Dr. Alexander Gibson was married Friday, August 22nd, to Helen Forbes Bryce, youngest daughter of Mr. and Mrs. Robert H. Bryce of Winnipeg. After the ceremony, Dr. and Mrs. Gibson left by motor for the Lake of the Woods and on their return will reside at 261 Harvard avenue.

♡ ♡ ♡

Surgeon-Lieutenant John Bingham, who spent the last year at sea, recently spent his leave visiting his parents, Mr. and Mrs. Richard Bingham of Winnipeg.

♡ ♡ ♡

Surgeon-Lieutenant R. L. Cook, recently attached to the Winnipeg division of the R.C.N.V.R., has been appointed to a post in the Naval service at the Pacific coast.

♡ ♡ ♡

Surgeon-Lieutenant Quentin Douglas Jacks, R.C.N.V.R., is to be married early in September at Victoria, B.C., to Marion Irene, daughter of Mr. and Mrs. C. A. Melvin.

♡ ♡ ♡

Dr. David Bradshaw Stewart, only son of the late Dr. and Mrs. D. A. Stewart of Ninette, Man., was recently married to Ruth Mae, eldest daughter of Mr. and Mrs. Stanley Rigby, of Killarney, Man.

♡ ♡ ♡

Dr. and Mrs. Fred. Jackson spent a short holiday at Clearwater Bay, Ont.

♡ ♡ ♡

The *Review* is always glad to receive items of a personal or social nature for this page; however, as the *Review* goes to press a week in advance of publication date, contributions must be in by the 20th of the month preceding date of issue.

Department of Health and Public Welfare

We are publishing herewith the second of the essays prepared by the medical students before taking the final examination in Preventive Medicine at the Faculty of Medicine of the University of Manitoba last year. The one for this month is written by Doctor G. S. Baldry, on the subject "The Value of Present Day Immunological Practice in Disease Prevention," and reads as follows:

"The Value of Present Day Immunological Practice in Disease Prevention"

FOREWORD

"In the evaluation of present day immunological practice in disease prevention many years must elapse before the true worth will be determined. Some results will show beyond doubt the value of prevention in diseases like smallpox and diphtheria, but others, like tuberculosis by the use of B.C.G. and the common cold, will take time.

"This paper will attempt to present the results of current practice in the various diseases involved. The value in figures and cases will be given whenever possible.

Smallpox

"A. Method:—

A drop of vaccine impregnated into the epidermis.

Children should be done first at 2 to 6 months:
again at 5 to 7 years;
again at 15 years of age.

Exposed persons should be vaccinated every 10 years and adults have one successful vaccination after puberty.

"B. Results:—

"Among unvaccinated less than 7% escape smallpox in a severe epidemic. (1)

"The fatality among unvaccinated is more than 50 times the fatality among the vaccinated at any time in their lives.

"Vaccination 4 days after exposure to a case of smallpox may prevent the disease.

"Doctor Groulx, Director of Dept. Health, Montreal, in his paper 'Elimination of Smallpox in Montreal by Vaccination' (2) reports the historical and effective vaccination in Montreal. First vaccinations were done in 1801 but it was 1876 before they were done on a large scale. In 1887, after a great epidemic, the Province of Quebec made it obligatory that all children over 3 months of age be vaccinated. The City of Montreal made this more effective in 1904 by requiring certificates of successful 'take' before admission to school or a place of employment.

Conclusion

"Prophylactic vaccination affords the most perfect immunity we have in medicine to a communicable and fatal disease. Its value is emphasized by the fact that there is no remedy once smallpox develops.

Scarlet Fever

"A. Thalhimer (3) reports the use of convalescent scarlet fever serum has been found efficient as a prophylactic. He found that about 85% of the children who were in intimate contact with patients with scarlet fever and who from experience, would be expected to develop the disease, failed to do so after receiving convalescent scarlet fever serum.

"B. Doctor George R. Walton of Regina (4) inoculated through his Department of Health, October 1st, 1938, to December 31st, 1939, 3,492 persons. During 1936, 1937 and 1938, a total of 1,323 cases of scarlet fever were reported, while in 1939 there were only 55 cases. Thirty-one were children of school age. Of this number only 3 had received preventive treatment.

"C. Results from Hamilton, Ont. (5):—

"Beginning 1936, 2,421 children in 15 schools were immunized. Following a recent severe epidemic, a survey of the value was made. Of 1,661 cases reported from September, 1939, to July 31st, 1940,

29.4% were in pre-school group
55.1% were in school group and
15.4% were over 16 years of age.

"Only 6 of the 2,421 children immunized or 0.36% were reported as having the disease in the epidemic. In each of 2 families, 3 immunized children escaped while one not immunized developed scarletina.

	No. of Pupils	Cases	Rate
15 schools in program	5,353	144	2.6%
36 schools no immunization	18,565	772	4.5%

Diphtheria

"Fraser (6) in his review of Diphtheria Toxoid states MacKinnon and Ross have shown that the incidence of diphtheria among children given three doses of toxoid (0.5, 0.5, 1cc. at intervals of 3 weeks) and living in an environment in which diphtheria was very prevalent, was only 10% of the incidence of this disease among other children living in the environment at the same time but not given toxoid. The reduction of 90% in incidence is a fair measure of the degree of protection afforded by diphtheria toxoid given as indicated above.

"In this same investigation it was shown that in the 2 dose group, the reduction was 76%. These studies had to be laid aside for the very gratifying reason that diphtheria cases became too infrequent and thus rendered invalid any conclusion as to the incidence in the inoculated as compared with the uninoculated groups of children. In cities where immunization has been intensive and directed toward the pre-school child, clinical cases of diphtheria have been rare or totally disappeared, as in Toronto, Hamilton, St. Catharines, and Brantford, Ontario.

Whooping Cough

"Doctor Harry Medovy of Winnipeg (7) reports on the prevention of Whooping Cough. A summary of his views are:

"1. Immunity conferred by serum is not and cannot be expected to be absolute.

"2. Contrary to earlier belief, the immunity derived from a previous attack of the disease itself is also far from absolute.

"3. In both cases it tends to break down when exposure is intimate or prolonged.

"4. Under less drastic conditions of exposure both the artificially and the naturally produced immunity appear to afford protection in a large proportion of cases. The protection from both sources appears to be approximately equal.

"5. There is evidence of partial protection when the immunized individual does acquire the disease as shown by briefer and milder symptoms.

Typhoid

"Malbin (8) reports on an epidemic of typhoid fever in a hospital population, 90% of which had been immunized against typhoid fever. The epidemic broke out in the military hospital at Vich, Spain, in the last week of April, 1938. The hospital at this time had 1,700 patients and a staff personnel of 200. The source of infection was one of three water supplies of the hospital which had become contaminated from the overflow of an adjacent sewerage system. The population of the hospital became constant for a period of five weeks with the outbreak of the epidemic. Questioning revealed that about 10% of the 1,900 members had never been vaccinated against typhoid fever while the remaining 90% had received two or more injections of typhoid vaccine from one year to three months prior to the epidemic.

"In all, there were 147 cases of typhoid fever proved by Widal tests and positive cultures from the blood, urine or stools and in several cases from all three sources. Forty-nine of these patients had never been vaccinated against the disease, or approximately 25% of the 190 unprotected persons. The remaining 98 patients had been previously immunized, giving an incidence of 6% for the immunized members of the hospital. The total incidence of the hospital was about 7.5%. The case fatality rate for the non-immunized group was 10.2% and for the immunized group, 4%. Only 14.3% of the immunized patients gave a typical typhoid clinical picture. Bradycardia, splenomegaly and leukopaenia, in order of frequency, were the constant features noted clinically.

Measles

"William Thalhimer of New York City Dept. of Health reports that using convalescent measles serum administered intramuscularily in the proper amount not later than the 6th-7th day after exposure will be followed by prevention or modification of the disease to an attenuated form in about 98% of instances. Four times the volume of pooled normal adult serum will have the same prophylactic efficacy. The modified attenuated disease confers an active permanent immunity.

"Since the mortality up to the age of 1 year is 8%. 1-3 years 5%, and the entire group under 5 is 1½%, this is a definite step in reduction of mortality in early age group.

Tetanus

"The value of a anti-tetanic serum has been proven for years. It is significant that every combatant in the allied forces was inoculated in the last war as well as every combatant in the current World War.

The Common Cold

"The value of vaccines in the common cold has not been conclusively reduced to mathematical results. There are many case reports and many types of vaccines used, the commonest being prepared stock vaccines and autogenous vaccines in the case of patients with chronic sinusitis and frequent colds. From a few cases I have seen among nurses and internes, in about one-third, the number of colds is definitely decreased. In about another third there isn't much difference noticed, and in the remaining third there definitely is no improvement. Better results are obtained with autogenous vaccines than with the stock preparations.

Tuberculosis

"There are many reports on the use of B.C.G. but many men who are leaders in Tuberculosis work in Canada express doubt as to the validity of the results because of the extreme difficulty in controlling the work. As the best results are to be expected among children of the tuberculous, it will be several years before accurate figures may be obtained. It is true that some of the children are in their teens but many of them had their cases poorly controlled. It is of definite value however.

"Other diseases using immunological procedures to good advantage include poliomyelitis; rabies must be mentioned.

"An excellent immunization program that may be followed for children is:

3- 6 mos.—Smallpox vaccine.
6- 8 mos.—Whooping cough vaccine.
9-12 mos.—Diphtheria toxoid.
18 mos.—1 dose Whooping Cough Vaccine (reinforcing).
1- 2 yrs.—Scarlet fever toxin.
2- 4 yrs.—1 dose of Diphtheria toxoid.
5-10 yrs.—Smallpox vaccine (reinforcing).
Typhoid inoculations may be added as required."

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COMMUNICABLE DISEASE REPORT

June 18th - July 15th, 1941

Chickenpox: Total 217—Winnipeg 94, Dauphin Town 40, St. James 18, Rockwood 12, Transcona 10, Unorganized 8, Manitou 7, Tuxedo 3, Pembina 3, Selkirk Town 3, Edward 3, Carberry Town 2, Brandon 1, Brenda 1, Fort Garry 1, Hillsburg 1, Kildonan West 1, McCreary 1, Sifton 1, St. Boniface 1, Albert 1 (Late Reported: Lakeview 3, St. James 2).

Measles: Total 149—Winnipeg 53, Flin Flon 13, Hamiota Rural 13, Rivers Town 12, Brenda 6, St. Boniface 6, Unorganized 5, Rockwood 5, Portage City 4, Blanshard 3, Daly 3, Kildonan East 2, Rhineland 2, Springfield 2, Tuxedo 2, Winnipeg Beach 2, Albert 1, Dauphin Town 1, Dauphin Rural 1, La Broquerie 1, Macdonald 1, Pembina 1, Pipestone 1, Portage Rural 1, Rosser 1, Shell River 1, Ste. Anne 1, St. James 1, Transcona 1 (Late Reported: Rhineland 2, Rivers Town 1).

Tuberculosis: Total 74—Unorganized 13, Winnipeg 12, Brandon 5, Dauphin Town 3, Dufferin 3, Ellice 3, Brokenhead 2, Glenwood 2, Rockwood 2, Selkirk Town 2, Victoria 2, Bifrost 1, Cartier 1, Dauphin Rural 1, Franklin 1, Glenella 1, Hamiota Rural 1, Hanover 1, Lansdowne 1, Lorne 1, Miniota 1, Minnedosa 1, Neepawa 1, Norfolk South 1, Portage Rural 1, Portage City 1, Rhineland 1, Rosedale 1, Stanley 1, St. Andrews 1, Ste. Anne 1, St. Boniface 1, St. Clements 1, St. Francois Xavier 1, St. James 1, St. Vital 1.

Mumps: Total 66—Winnipeg 26, Tuxedo 20, Flin Flon 9, Brandon 2, Macdonald 2, Fort Garry 1, St. James 1 (Late Reported: St. James 3, Flin Flon 1, Lakeview 1).

Scarlet Fever: Total 33—Winnipeg 15, Portage City 5, Tuxedo 3, Kildonan West 2, Ochre River 2, Unorganized 2, Flin Flon 1, Norfolk North 1, St. Boniface 1 (Late Reported: Kildonan West 1).

Anterior Poliomyelitis: Total 28—Winnipeg 21, Fort Garry 2, Kildonan East 2, Springfield 1, St. Clements 1 (Late Reported: Lakeview 1).

German Measles: Total 16—Brandon 12, Flin Flon 3, Ste. Anne 1.

Diphtheria: Total 15—Winnipeg 4, Unorganized 4, St. Clements 3, St. James 2, Whitemouth 1, McCreary 1.

Whooping Cough: Total 7—Winnipeg 3, Brandon 2 (Late Reported: Cartier 1, Hanover 1).

Septic Sore Throat: Total 5—Cartier 1, Gladstone 1, Springfield 1, St. James 1 (Late Reported: Gimli Rural 1).

Influenza: Total 5—Carberry Town 1 (Late Reported: Carberry 2, West Kildonan 1, Unorganized 1).

Typhoid Fever: Total 4—Hanover 1 (Late Reported: Ste. Anne 2, Grandview Rural 1).

Erysipelas: Total 4—Winnipeg 2, Assiniboia 1, St. Clements 1.

Pneumonia Lobar: Total 3—Unorganized 1, Brandon 1 (Late Reported: Old Kildonan 1).

Meningococcal Meningitis: Total 2—Winnipeg 2.

Undulant Fever: Total 2—Winnipeg 2.

Puerperal Fever: Total 1—(Late Reported: Unorganized 1).

Trachoma: Total 1—(Late Reported: Hanover 1).

Diphtheria Carriers: Total 1—Winnipeg 1.

Treaty Indians: Total 15—Tuberculosis 14, Pneumonia Lobar 1.

Venereal Disease: Total 137—Gonorrhoea 101, Syphilis 36.

DEATHS FROM COMMUNICABLE DISEASE
June - 1941

URBAN—Cancer 50, Tuberculosis 8, Pneumonia Lobar 2, Pneumonia (other forms) 6, Syphilis 3, Diphtheria 1, German Measles 1, other deaths under one year 21, other deaths over one year 189, Stillbirths 20. Total 301.

RURAL—Cancer 33, Tuberculosis 18, Pneumonia Lobar 2, Pneumonia (other forms) 7, Dysentry 2, Influenza 2, Measles 1, Syphilis 1, other deaths under one year 21, other deaths over one year 152, Stillbirths 23. Total 262.

INDIAN—Tuberculosis 8, Pneumonia Lobar 1, Pneumonia (other forms) 4, Dysentry 3, Septic Sore Throat 1, other deaths under one year 6, other deaths over one year 7. Total 30.

Disease	Manitoba June 18 - July 15	Ontario June 15 - July 12	Saskatchewan June 15 - July 12	Minnesota June 15 - July 12	North Dakota June 15 - July 12
Anterior Poliomyelitis	27	5	2	11	
Meningococcal Meningitis	2	34	4		1
Chickenpox	212	829	166	205	
Diphtheria	15	17	2	4	4
Erysipelas	4	6	6	2	
Influenza	1	70	2		15
Measles	146	2,300	104	48	53
German Measles	16	593	38		
Mumps	61	423	78		
Pneumonia (Lobar)	2				22
Scarlet Fever	32	509	23	87	6
Septic Sore Throat	4	21			
Smallpox			1	2	
Tuberculosis	74	183	68	152	22
Typhoid, Para-Typhoid	1	17			1
Undulant Fever	2	8	1		
Whooping Cough	5	534	2	288	84

It is noted that Saskatchewan and Minnesota still report a case or two of Smallpox.

The Epidemic of Poliomyelitis is rising rapidly in Manitoba and at the time of going to press has probably reached its peak.

Encephalitis is prevalent in Minnesota, North Dakota and Manitoba, and should be watched for. Some cases are much like poliomyelitis but careful examination and history will give a definite diagnosis in the majority.

25,000 VITAMIN A UNITS U.S.P. XI SQUIBB NOW AVAILABLE IN 2 MINIM CAPSULES

As a result of the demand for a highly potent source of vitamin A unaccompanied by Vitamin D, E. R. Squibb & Sons, New York, have added Vitamin A Squibb to their already extensive line of vitamin products. Vitamin A Squibb is supplied in tiny capsules of approximately 2 minims, each containing not less than 25,000 U.S.P. XI units of vitamin A derived from fish liver oils. The labelled potency is assured by biological tests.

For some time physicians have been asking for a highly potent source of vitamin A — a source making possible the administration of quantities of vitamin A (without increasing the intake of vitamin D) much greater than that afforded by plain halibut liver oil as now supplied — yet keeping the dosage volume at a minimum. There are several conditions in which such a product is particularly indicated. These include:

1. Increased requirement.
2. Decreased intake.
3. Impaired intestinal absorption—a condition not infrequently associated in infancy with cretinism, celiac disease, fibrosis of the pancreas and congenital obliteration of the bile duct.
4. Metabolic disorders, as in diabetes mellitus in which the ability of the patient to convert carotene present in foods into vitamin A is greatly reduced.
5. Treatment of conditions due to marked vitamin A deficiency.

In severe vitamin A deficiency, especially in the presence of impaired intestinal absorption, four capsules of Vitamin A Squibb are the suggested daily dose; in diabetes mellitus, Vitamin A Squibb may be used as a diet supplement with one capsule being taken three times a week.

Vitamin A Squibb is supplied in bottles of 50, 100, 250 and 1,000. —Adv.